

FILED APR 18 1940

# MISSOURI STATE BOARD OF HEALTH

## BUREAU OF VITAL STATISTICS

### CERTIFICATE OF DEATH

9995

Do not use this space.

## 1. PLACE OF DEATH

(a) County Adair Registration District No. 4  
 (b) Township Kirksville Primary Registration District No. 3001 Registered No. 72  
 (c) City Kirksville (d) Street No. Brun Smith Hospital St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

## 2. PRINT FULL NAME

(a) Residence, No. Robert Keith Williams St. Elmer, Mo.  
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept. 24-1917  
 7. AGE YEARS 22 MONTHS 6 DAYS 1 If LESS than 1 day, ..... hrs. or ..... min.  
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer  
 9. Industry or business in which work was done, as saw mill, bank, etc. 1  
 10. Date deceased last worked at this occupation (month and year) ..... 11. Total time (years) spent in this occupation.....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

FATHER 13. NAME Robert T. Williams

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

MOTHER 15. MAIDEN NAME Grace M. Palmerton

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

17. INFORMANT (ADDRESS) Robert T. Williams  
Elmer, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Elmer DATE Mar. 27 1940

19. FUNERAL DIRECTOR (NAME) Clyde McCallum  
(ADDRESS) Elmer, Mo.

20. FILED 3-30 1940 Lawrence L. Freeman  
Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 25 1940

22. I HEREBY CERTIFY, That I attended deceased from March 14 1940, to March 25 1940

I last saw him alive on March 25 1940 Death is said to have occurred on the date stated above, at 4 A. m.

The principal cause of death and related causes of importance were as follows:

Hemorrhagic nephritis - Uremia Date of onset 3-24-40  
(acute)

Other contributory causes of importance:

Name of operation L Date of L

What test confirmed diagnosis? L.A. Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? ..... Date of injury ..... 19.....

Where did injury occur? (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? No  
 If so, specify.....

(Signed) J. J. Pump M. D.

(Address) Kirksville, Mo.

130  
RECEIVED

District Health Officer No. 10

District File Number 4-40-806

Date Filed APR 16 1940

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

*Clyde McCallum*

, or by

Registered Apprentice No. ...., working under my personal supervision.

Signed

*Clyde McCallum*

Licensed Embalmer No. 3226

P. O. Address

*Elmer, Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **9985-**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. **4**

Primary Registration District No. **3001**

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County **Adair**  
(b) City or town **Farmville**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether  
In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME **Robert Keith William**

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex **m** 5. Color or race **w** 6. (a) Single, widowed, married, divorced **8**

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

7. Birth date of deceased \_\_\_\_\_  
(Month) (Day) (Year)

8. AGE: Years **22** Months **6** Days **1** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_  
15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_

(c) City or town \_\_\_\_\_  
(If outside city or town limits write "RURAL")

(d) Street No. \_\_\_\_\_  
(If rural, give location)

(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month **Mar** day **25**  
year **1970** hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death **hemorrhage nephritis chronic acute**

Due to **unknown**

(acute exacerbation of chronic)

Due to **type ??**

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_

23. Signature **J. H. Hume** (M. D. or other) \_\_\_\_\_

Address **Farmville** Date **25**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENT

S-9995